STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100645	A. BUILDING: _____ B. WING _____	C 07/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	INITIAL COMMENTS A Complaint Survey was initiated on 07/24/15 and concluded on 07/25/15, to investigate KY23587. The Division of Heath Care substantiated the allegation with deficiencies cited.	N 000		
N 105	902 KAR 20:300-5(3) Section 5. Resident Behavior & Fac. Practice (3) Staff treatment of residents. The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of residents. This requirement is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to follow their Abuse Policy, to report and initiate an investigation for injuries of unknown origin for one (1) of three (3) sampled residents, Resident #1. The findings include: Review of the facility's Abuse Policy, revised 06/01/15, revealed on page seven (7) under the heading: Procedure for Reporting Abuse stated, all reported events (bruises, skin tears, falls, or abusive behaviors) would be investigated by the Director of Clinical Services and reported to the Executive Director. Once an allegation had been reported to the facility, timely reporting would follow to Federal and State agencies, including notification of Law Enforcement if applicable.	N 105		

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N 105	Continued From page 1 Review of the nursing documentation, on 07/23/15, revealed Resident #1 sustained a laceration over the left eye and a contusion to the left upper cheek from an unknown cause at 1:15 PM. Interview with the Certified Nursing Assistant (CNA) #1, on 07/25/15 at 8:55 AM, revealed the resident was ambulating from the dining room to his/her room after lunch at approximately 1:15 PM. The resident went into his/her room and came back out holding clothes in his/her arms. CNA #1 instructed the resident to return the clothes to his/her room and she would get a laundry bag for the clothes to be put in. The resident went back into his/her room to return the clothes and when the resident came back out of the room he/she had a laceration over the left eye and a contusion on the upper left cheek. The CNA also stated at the time the resident went back into his/her room and incurred the injury there was no sound as if the resident had fallen. She immediately called the nurse to assess the resident. Interview with Registered Nurse #1, on 07/25/15 at 9:20 AM, revealed she assessed Resident #1, notified the Administrator and Director of Nursing and EMS was called to transport the resident to a local hospital for evaluation. There was no documented evidence the facility initiated an investigation per the facility's policy. Review of the facsimile to the State Survey Agency (SSA) revealed the incident was reported on 07/24/15 at 5:27 PM, the next day. The report read: Resident #1 had an injury of an unknown source. The resident had a cognitive disorder	N 105		

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N 105	Continued From page 2 following a diagnosis of Cardiovascular Disease. An investigation would be initiated to identify causative factors and a five (5) day final report/summary would be provided. Review of the initial facility report revealed the facility did not report the injury of unknown origin timely per the facility's policy, The report was not received until the day after the injury occurred. Interview with the Administrator, on 07/25/15 at 11:00 AM, revealed the facility faxed the report of the injury of unknown origin to the SSA, on 07/24/15 at 5:28 PM. He stated the facility was unable to determine how the injury occurred and he did not think the incident was reportable.	N 105		
N 107	902 KAR 20:300-5(3)(a)2. Section 5. Resident Behavior & Fac. Practice (3) Staff treatment of residents. (a) The facility shall: 2. Not employ individuals who have been convicted of abusing, neglecting or mistreating individuals. This requirement is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to report an injury of unknown origin in a timely manner for one (1) of three (3) sampled	N 107		

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N 107	Continued From page 3	N 107		

residents, Resident #1.

The findings include:

Review of the facility's Abuse Policy, revised 06/01/15, revealed on page seven (7) under the heading Procedure for Reporting Abuse revealed, all reported events (bruises, skin tears, falls, or abusive behaviors) would be investigated by the Director of Clinical Services and reported to the Executive Director. Once an allegation had been reported to the facility, timely reporting would follow to Federal and State agencies, including notification of Law Enforcement if applicable.

Review of the clinical record for Resident #1 revealed the facility admitted the resident on 05/14/14 with diagnoses of Acute Respiratory Failure, Lack of Coordination, Cerebrovascular Disease, Dysphagia, Asphasia, Seizures, High B/P, and High Lipids. Resident #1 was non-verbal after a CVA.

Review of the Nursing Notes, dated 07/23/15, revealed the Certified Nursing Assistant (CNA) called the nurse at approximately 1:15 PM to assess Resident #1. Resident #1 was standing in the hallway with a bleeding laceration over the left eye and a golf ball size contusion on the upper left cheek below the eye. When the nurse looked in the resident's room there was blood splattered on the floor.

Further review revealed, on 07/23/15 at 1:45 PM, Resident
#1 was transported to the Emergency Department at a local hospital for evaluation.

Review of the Care Plan, dated 05/26/15, revealed Resident #1 had a history of falls and at

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N 107	Continued From page 4 times was unsteady on his/her feet. He/she was released on 06/25/15 from Physical Therapy for meeting his/her strengthening goals. On 06/25/15 when he/she was released from therapy the care plan was updated for the staff to encourage him/her to use a wheelchair or a walker on the unit. Review of the facsimile to the State Survey Agency (SSA) revealed the incident was reported, on 07/24/15 at 5:27 PM, the next day. The report read: Resident #1 had an injury of an unknown source. The resident had a cognitive disorder following a diagnosis of Cardiovascular Disease. An investigation would be initiated to identify causative factors and a five (5) day final report/summary would be provided. Interview with the Administrator, on 07/25/15 at 11:00 AM, revealed the facility faxed the report of the injury of unknown origin to the SSA, 07/24/15 at 5:28 PM. He stated the facility was unable to determine how the injury occurred; however, he did not think the incident was reportable.	N 107		